Rapid Expansion of Popliteal Artery Aneurysm after Lower Limb Graduated Compression Bandaging for Varicose Ulcer

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We present the case of an 80-year-old woman who presented with rapid expansion of a right popliteal artery aneurysm. She had been treated with high-pressure graduated compression bandaging for a right lower leg ulcer prior to the sudden development of a painful swelling behind her right knee, diagnosed on ultrasound scan as a large non-ruptured popliteal artery aneurysm. She was treated successfully by reversed autologous vein graft bypass and exclusion of her popliteal artery aneurysm. This case suggests compression bandaging of the lower leg may be associated with rapid expansion of a previously undiagnosed popliteal artery aneurysm.

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Deep Vein Thrombosis through Remnant Great Saphenous Vein Following Vein Harvest

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Introduction. *Great saphenous vein (GSV) harvest is common practice in vascular and cardiothoracic surgery. Thrombosis of the proximal remnant of vein with propagation into the femoral vein has not been reported before.*
Case report. *The distal half of the GSV was harvested for remote grafting of an axillary artery injury. Three months later the patient presented with thrombosis of the proximal remnant with extension of the thrombus into the femoral vein. This was successfully treated by high ligation and extraction of thrombus.*
Discussion. *Leaving a proximal remnant of the GSV in the thigh can lead to thrombosis, and the potential lethal complication of thrombus extension through the sapheno-femoral junction with the possibility of pulmonary embolism. We suggest that if the great saphenous vein is harvested in the distal thigh, the sapheno-femoral junction should be flush-ligated to prevent this complication.*

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Endovascular Treatment of a Mycotic Subclavian Artery Aneurysm Using Stent-graft

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We report a case of an immuno-suppressed 49-year-old man with mycotic aneurysm of left subclavian artery. The aneurysm was diagnosed by computed tomography and digital subtraction angiography. Our choice for treatment was endovascular stent-graft implantation. After stent-graft implantation, type I endoleak was present because of the aneurysm had broad neck and, so, we implanted second stent-graft proximally to the first stent. The end of the procedure, there was a minimal type III endoleak into the aneurysm sac. The patient was well and free of symptoms after 1 week. A control CT Angiography, after five months, showed a completely thrombosed aneurysm without an endoleak. Endovascular repair of a mycotic subclavian artery aneurysm may be an alternative to open surgery.

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